SECTION 14. HOW TO FILE A CLAIM

WHEN TO FILE

Once coverage begins, you may file for benefits as soon as you incur a covered expense. However, it is recommended that all requests for benefit payments be submitted to Blue Cross and Blue Shield of Alabama within 90 days after the medical expenses are incurred. For hospitalization, the hospital and physician will normally file your claims. (Separate claims must be filed for each covered dependent.)

The provider or participant must file the Claims no later than 12 months from the date of the service. Claims received after one year from the date the expenses were incurred will not be covered or paid.

FILING CLAIMS WHEN COORDINATION OF BENEFITS (COB) APPLIES

Requests for benefit payments should always be filed with the primary plan first. When COB rules determine that MAP is secondary, MAP payments will be delayed until you provide information on your other available group plan coverage. It is your responsibility to keep enrollment information for yourself and your dependents current on your Company Enrollment Records. To make changes, please call your Benefit Office. If you fail to do so, it may result in delayed, reduced, or denied payments.

Retired employees enrolled in Medicare should always file with Medicare first, then attach their Explanation of Medicare Benefits (EOMB) and itemized bill to the Medical Plan Claim Form. Timely filing provisions apply to all MAP claims, even if Medicare or another insurance is primary.

HOW TO FILE

You may request MAP benefits by using the Medical Plan Claim Form or, if your expense is for prescription drugs, by using the Medical Plan Prescription Drug Claim Form. You may obtain Claim Forms by calling Blue Cross and Blue Shield of Alabama at 1-800-633-8915. A recording will ask a series of questions to which you will respond. Then your request will be processed. For obtaining information on prescription drugs through the Mail Order Prescription Drug Program or the PPO pharmacy network, see Section 10.

Medical Plan Claim Form

Claim Form must include:

- Employee's/Retiree's full name and Contract Number (BLS plus Social Security number) as shown on the BellSouth Medical Plan Identification Card
- Spouse's employment and other medical coverage information
- Patient's full name and date of birth
- Date and place of service
- Diagnosis/Illness
- Type of service
- Amount of charges
- Registration or license number of registered nurse or licensed practical nurse, when applicable

Medical Plan Prescription Drug Claim Form

Claim Form must include:

- The prescription number
- The National Drug Code (NDC) provided by your pharmacist
- Pharmacy name and address
- Date filled

- Whether your physician required a brandname rather than a generic substitute
- Whether a generic substitute was available from your pharmacist
- The quantity dispensed (e.g., "30 tablets")
- Your signature
- Proof of purchase, such as the original or copy of an itemized receipt

Providing Blue Cross and Blue Shield of Alabama with complete, accurate information as requested on the Claim Form helps assure that your claims will be processed in a timely manner. **For your reference, you should keep copies of your Claim Forms, bills and any other supporting records.**

Mail the completed forms and itemized receipts to:

Blue Cross and Blue Shield of Alabama
BellSouth Dedicated Service Center
P.O. Box 830279
Birmingham, Alabama 35283-0279

HOW BENEFITS ARE PAID

The following examples illustrate how MAP benefits are paid. In each example, we will assume the $165 deductible has been met. As a reminder, the OCR penalty is $250 for non-certification.

#3
The employee lives in a non-PPO area and uses a non-PPO hospital and a non-PPO physician. The charges are within R&C limits.

	Charges	MAP Pays	Employee Pays	Applied to Out-of-Pocket
Hospital	$5,000	$5,000 (100% covered charges)	- 0 -	- 0 -
Physician (surgery charge)	$1,500	$1,350 (90% of $1500–R&C)	$150	$150
Total, if QCP Pre-certifies	$6,500	$6,350	$150	$150
Total, if not Pre-certified	$6,500	$6,100	$400 (includes $250 penalty)	$150

#4
Assume:

- Medicare is Primary
- Deductibles under both Medicare and MAP have been satisfied.
- Medicare's benefit level is 80%.
- MAP's benefit level is 90%.
- Physician's charge is $120, which is within R&C.

	Physician Charge	Medicare Allowance	Medicare Pays	Maximum Charge	MAP Pays	Participant Pays
Physician Accepts Assignment	$120	$100	$80 ($100 × 80%)	$100	$10 ($100 × 90% minus Medicare payment)	$10 ($100 minus Medicare payment minus MAP payment)
Physician DOES NOT Accept Assignment	$120	$95* ($100 × 95%)	$76 ($95 × 80%)	$114** ($95 × 120%)	$26.60 ($114 × 90% minus Medicare payment)	$11.40 ($114 minus Medicare payment minus MAP payment)

*Effective January 1, 1992, the Medicare Allowance was reduced to 95% for physicians who do not accept the Medicare assignment.

**Effective January 1, 1992, physicians who do not accept the Medicare assignment cannot charge Medicare patients more than 20% above the Medicare Allowance. (In 1993, that limit will be lowered to 15%.)

The Participant is not responsible for the difference between the physician's charge and the maximum charge.

SECTION 15. WHEN COVERAGE ENDS OR CHANGES

There are several circumstances in which the coverage you have as an active employee or retiree can end or change.

TERMINATION OF COVERAGE

Coverage for you and your dependents ends if your employment terminates for reasons other than retirement on a service or disability pension, receipt of LTD benefits, layoff under the terms of the working agreement, provisions of one of the non-management force-adjustment plans, or death. Coverage ends on the last day of the month in which your employment ends.

Coverage also ends on the last day of the month in which:

- You request that your coverage be canceled for any reason, **or**
- A required payment is not made, **or**
- You begin a military leave.

If your coverage ends, your dependents' coverage also ends. A dependent's coverage will end on the last day of the month in which:

- A required payment is not made, **or**
- A dependent no longer qualifies as a dependent (as defined in Section 1) because of age, a change in full-time student status, marital status, residency or income.

If coverage ends at the end of a month, MAP will not pay benefits for expenses incurred after the end of that month unless the participant is in the hospital on the last day of the month. In that case, only Hospital Care Benefits will be paid for the remaining days of the admission (see Section 7). All benefits will end with that admission.

Continued Coverage Under COBRA

If you terminate employment for reasons other than gross misconduct, you or your covered dependents may elect to continue coverage under COBRA by paying 102% of the group rate for up to 18 months (see Section 16). At the appropriate time, the Company will provide you with information on how to elect continued coverage under COBRA.

If your dependent no longer qualifies as a dependent under MAP, COBRA coverage may be available.

WHEN YOU RETIRE

If you retire from the Company on a service or disability pension, the Company currently continues coverage for you and your eligible dependents during your retirement through the last day of the month in which you die. However, the Company reserves the right, at its discretion, to modify coverage, including reduction or elimination of coverage or requiring retirees to pay all or a greater portion of the cost of coverage.

Currently, retiree coverage is the same as coverage for active employees with the following exceptions:

- Once you or any of your dependents meet the criteria for Medicare eligibility, benefits will be reduced by payments available from Medicare
- The individual lifetime benefit maximum of $1,000,000 applies to all MAP payments for each retiree and dependent beginning on January 1 following your retirement
- For management employees who retire on or after January 1, 1992, MAP will provide secondary coverage when the retiree becomes employed at another company, and the new employer offers a group plan and pays:

- All or any part of the cost of coverage for employees who work 30 or more hours per week, or
- Half the cost of coverage for employees who work less than 30 hours per week, and
- 25% or more of the cost of coverage for dependents, including children.

Under this provision, MAP pays normal benefits minus those that would have been paid by the new employer's plan, regardless of the participant's enrollment status.

The cost of retiree coverage is explained in Section 4.

Continued Coverage Under COBRA

As an alternative to the retiree coverage, you or your covered dependents may be eligible to elect to continue coverage under COBRA by paying 102% of the group rate for up to 18 months from your pension effective date (see Section 16). At the appropriate time, the Company will provide you with information on how to elect continued coverage under COBRA.

If COBRA coverage is elected, MAP currently provides that the then applicable retiree coverage, if any, as explained in the previous paragraphs, will automatically begin when COBRA coverage ends for any reason.

Competitor Rule and Benefit Forfeiture

All employees who retire on or after January 1, 1991, may forfeit their right and their dependents' right to certain post-retirement benefits if, during the five years following retirement from BellSouth, they provide services to or acquire an interest in a BellSouth competitor. It is important to understand that once such coverage is terminated, it will not be reinstated.

Definition

A Competitor of BellSouth or its affiliates is one who, in BellSouth's judgment, is engaged directly or through an affiliate in any line of business in which BellSouth or one or more of its affiliates is engaged, such as, but not limited to: the provision of telecommunications goods or services; the printing, publication, or provision of classified directories; the provision of cellular communications; and the provision of paging goods or services.

As set forth in the BellSouth Medical Assistance Plan, Dental Assistance Plan, Group Life Insurance Plan, and the Death Benefit provisions of the Pension Plan or the Management Pension Plan, a former employee will forfeit his/her entitlement to post-retirement benefits under the foregoing plans if, during the five year period following the employee's retirement:

a. The employee acquires ownership of more than 5% of any class of stock of, or acquires beneficial ownership of, more than 5% of the earnings or profits of a Competitor, or

b. The employee becomes employed by, renders services to, or consults with a Competitor, unless the employee's activities on behalf of the Competitor make no use, directly or indirectly of: 1) BellSouth proprietary or customer information, or 2) skills that the employee developed or used, or training provided to the employee during the last five years of the employee's employment by BellSouth or any of its affiliates.

During the five year period over which the Forfeiture Provision is applicable, the business activities of BellSouth and its affiliates at the point in time that a former employee acquires an ownership interest in, or becomes employed by, changes assignments with, renders services to, or consults with another business entity will determine whether that entity is a Competitor.

Health and welfare benefits are deemed terminated upon the date of occurrence of the forfeiture event, i.e., the date that more than 5% ownership interest in a competitor is acquired, or the date that employment with a competitor is begun. Upon learning of a forfeiture event, BellSouth reserves the right to seek the reimbursement of any benefits that were paid following the occurrence of that event.

Request for Benefit Forfeiture Ruling
An employee may file a "Request for Benefits Forfeiture Ruling" with the retiree benefit organization before acquiring an ownership or beneficial interest in another entity or before engaging in any post-retirement employment activity. On the basis of the information included in the Request, the employee will receive a binding determination, based on the activity described in the Request, as to whether the entity is a competitor, and if applicable, if the activity in question is deemed to be in competition with BellSouth.

Employees who disagree with the response that they receive to a Request for Benefits Forfeiture Ruling may request to have that response reviewed. In order to prevent a possible forfeiture, such a review should be indicated and completed before engaging in the activity at issue.

The review request must be in writing and should be made, within 60 days of the receipt of the response, to the Secretary of their Company's Employees' Benefit Committee. All supporting information and documents should accompany this submission. The Company Employees' Benefit Committee will issue a final, written decision within 120 days.

The addresses of the various Company Employees' Benefit Committee are listed below:

For BellSouth Business Systems; BellSouth Communications, Inc.; BellSouth Communications Systems; BellSouth Corporation; BellSouth D.C., Inc.; and BellSouth Telecommunications, Inc.
Room 18H62 Southern Bell Center
675 W. Peachtree Street, N.E.
Atlanta, Georgia 30375

For BellSouth Advertising & Publishing Corporation; BellSouth Enterprises, Inc.; BellSouth Financial Services Corporation; BellSouth Information Systems, Inc.; BellSouth International, Inc.; BellSouth Mobility, Inc.; BellSouth Resources, Inc.; Sunlink Corporation; Intelligent Media Services, Inc.; Intelligent Messaging Services, Inc.
Room 5C08
1100 Peachtree Street, N.E.
Atlanta, Georgia 30309

Forfeiture Appeals
Employees who have their benefits eligibility terminated under the Forfeiture Provision may, on their own behalf or through a representative, have that action reviewed by submitting a written appeal within 60 days of their receipt of the notification of termination or eligibility to the Secretary of their Company's Employees' Benefit Committee at the address shown above.

If the appeal is denied, the employee will receive written notice of the Employees' Benefit Committee's decision, including the specific reasons for the decision and the procedures for appealing the decision, within 90 days of the date the Committee received the appeal.

In some cases, the Committee may need more than 90 days to make a decision. In such cases, the Committee will notify the employee in writing within the initial 90-day period and explain why more time is needed. An additional 90 days may be taken to make the decision if the Committee sends this notice. The extension notice will show the date by which the Committee's decision will be sent. If the Committee does not give its decision within the designated time span, the appeal is deemed to be denied.

An employee whose appeal to the Employees' Benefit Committee is denied, or deemed denied where no reply is received within 90 days, or if an extension was requested, within 180 days, may challenge such a denial by

submitting a written appeal to the Secretary of the BellSouth Corporation Employees' Benefit Claim Review Committee at the following address:

Room 1927
1155 Peachtree Street, N.E.
Atlanta, Georgia 30367-6000.

Such an appeal must be submitted in writing within 60 days after the receipt of the Employees' Benefit Committee's denial notification, or if no denial is received, within 60 days of the date that the original appeal was deemed to be denied. The Employees' Benefit Claim Review Committee will conduct a review and issue a determination within 60 days after receipt of the appeal. In some cases, the Claim Review Committee may need more than 60 days to make a decision. In such cases, the Claim Review Comittee will notify the employee in writing within the initial 60-day period and explain why more time is needed. The Employees' Benefit Claim Review Committee may then have 60 days more, or a total of 120 days, in which to make its decision.

The Employees' Benefit Claim Review Committee will issue a final written decision that will include specific reasons for the decision. If the Employees' Benefit Claim Review Committee does not issue its decision within the appropriate time span, the appeal is deemed to be denied.

In submitting an appeal either to the Employees' Benefit Committee or the Employees' Benefit Claim Review Committee, the employee is entitled to include a written statement of the issues and any other documents in support of the appeal. All material provided to either committee will be carefully considered in the determination.

BellSouth has delegated to the Company Employees' Benefit Committees and the BellSouth Corporation Employees' Benefit Claim Review Committee the duty to administer the appeal of benefit eligibility terminations under the Forfeiture Provision. The Company Employees' Benefit Committees and the BellSouth Employees' Benefit Claim Review Committee have the discretion and authority to interpret and to enforce the Forfeiture Provision and their determinations and interpretations are final and conclusive.

As a participant in the various benefit plans subject to the Forfeiture Provision, you have further rights under the Employee Retirement Income Security Act of 1974 and the Consolidated Omnibus Budget Reconciliation Act of 1986. Those rights are described in detail in the Summary Plan Descriptions issued for each affected plan.

IF YOU BECOME DISABLED

If you become disabled before retirement and are eligible to receive benefits under one of the Company's Long-Term Disability (LTD) Plans, MAP coverage for you and your dependents will continue.

Coverage is currently the same as for active employees with the following exceptions:

- Once you or any of your dependents meet the criteria for Medicare eligibility, benefits will be reduced by payments available from Medicare.
- The individual lifetime benefit maximum of $1,000,000 applies to you and each dependent beginning on January 1 following your eligibility for LTD benefits.
- There are no substance abuse rehabilitation benefits for expenses incurred by you or your dependents on or after the first day of the month following your eligibility for LTD benefits.

The Company currently pays the full cost of coverage for you and your Class I dependents while you are LTD eligible with regular contributions required for all other dependents. However, the Company reserves the right to modify coverage, at its discretion, including reduction, elimination of coverage, or requiring you to pay all or a portion of the cost of coverage, subject to applicable collective bargaining agreements.

Continued Coverage Under COBRA
As an alternative to LTD coverage, you or your covered dependents may be eligible to elect to continue coverage under COBRA by paying 102% of the group rate for up to 18 months from the first of the month following the month in which you became disabled (see Section 16). If you are receiving Social Security disability benefits, and if you qualify, the 18-month period may be extended to a 29-month period by paying 150% of the group rate during the 19-29 months. At the appropriate time, the Company will provide you with information on how to elect continued coverage under COBRA.

If COBRA coverage is elected, MAP currently provides that the then applicable coverage for LTD-eligibles (explained above), if any, will automatically begin when COBRA coverage ends for any reason.

WHEN YOU DIE
If you die while you are an employee or retiree, MAP coverage may continue for your surviving spouse and your Class I and Class II dependents who are covered on the date of your death. Dependent coverage will continue unless you do not have a surviving spouse, in which case benefits for your dependents will end on the last day of the month in which you die. Regardless of your marital status, coverage for your sponsored children will end on the last day of the month in which you die.

Your surviving spouse may elect to continue coverage on himself/herself and your Class I and Class II dependents. (Sponsored dependents do not qualify for surviving spouse benefits.) The Company provides full coverage for the first six months. Following the last day of the sixth month after your death, your spouse may elect coverage by paying 100% of the group rate.

Coverage for a surviving spouse and Class I and Class II dependents of a deceased **active** employee is the same as for active employees except:

- The coverage is available only for Class I and Class II dependents who are covered on the day of your death. Your spouse cannot enroll any new Class I or Class II dependents.
- There is an individual lifetime benefit maximum of $1,000,000 which applies to all MAP payments beginning on January 1 following each participant's (your spouse's and each dependent's) 65th birthday.

Coverage for a surviving spouse and Class I and Class II dependents of a deceased **retired** employee is the same as for retired employees except:

- The coverage is only available for Class I and Class II dependents who are covered on the day of your death. Your spouse cannot enroll any new Class I or Class II dependents.

The Company reserves the right to modify coverage, at its discretion, including reduction, elimination of coverage, or requiring a surviving spouse to pay all or a greater portion of the cost of coverage.

Continued Coverage Under COBRA
As an alternative to surviving spouse coverage after the death of an active employee, your covered dependents may elect to continue coverage under COBRA by paying 102% of the group rate for up to 36 months (see Section 16). At the appropriate time, the Company will provide your dependents with information on how to elect continued coverage under COBRA. After the death of a retiree, your covered dependents may, under certain circumstances, elect COBRA coverage for up to 36 months from the date of your retirement, if death occurred within 18 months of retirement.

If COBRA coverage is elected, your surviving spouse and Class I and Class II dependents will automatically be eligible for coverage which MAP currently provides for the then applicable survivor coverage, if any, according to Company policy (see above) when COBRA coverage ends for any reason.

LEAVE OF ABSENCE

In the case of an approved Leave of Absence, MAP currently provides that you can continue coverage for yourself and your dependents for the duration of the approved leave by paying the full cost of coverage unless the leave is an approved Care of a Newborn Child (CNC) Leave or Dependent Care Leave. In that case, the Company will pay the full cost of MAP coverage for up to 6 months during the leave in any 2-year period if you were eligible to receive Company-paid coverage prior to the CNC or Dependent Care Leave.

For persons considering a Sabbatical Leave of Absence (SLOA) or participation in the Career Alternative Program (CAP), please contact your Benefit Office for coverage information.

Under MAP, a leave to enter military service is not considered an approved leave. If you enter military service, coverage for you and your dependents will end on the last day of the month in which you are an active employee.

If you are planning to go on an approved Leave of Absence (other than military leave), and you are also an eligible dependent of an active employee, you may request to transfer your medical coverage as an active employee to coverage as a dependent of an active employee without any break in coverage. Your request should be made before your Leave of Absence begins.

The Company reserves the right to modify coverage, at its discretion, including reduction or elimination of coverage, subject to applicable collective bargaining agreements.

Continued Coverage Under COBRA

If you are a MAP participant on an approved Leave of Absence and do not return to work at the termination of your leave, you or your dependents may elect to continue coverage under COBRA for up to 18 months by paying 102% of the group rate as long as you continued coverage while you were on leave (see Section 16).

EXTENDED MEDICAL COVERAGE

Non-management employees covered under MAP who are not eligible for a Company service or disability pension and are either laid-off or leave the Company under the provisions a force-adjustment plan, may continue coverage for up to 12 months (based on the terms of their force-adjustment plan) beginning on the first day of the month following layoff/separation. The period of Company contributions for continued coverage is currently based on net credited service as follows:

- Former employees with five or more years of net credited service will continue to receive current levels of Company-paid medical coverage for up to six months. The former employee may then continue coverage for the next six months by paying 100% of the monthly group rate.
- Former employees with more than one year but less than five years of net credited service will receive three months of the current level of Company-paid coverage with an option to pay 100% of the group rate for an additional nine months of coverage.
- An employee with less than one year of service may elect to pay 100% of the group rate for coverage for twelve months.

The continued coverage will be the same as the coverage then provided to active employees. Therefore, any changes in benefits or contributions for active employees will be applied to participants in this extended medical coverage program. The Company reserves the right to modify coverage, at its discretion, including reduction, elimination, or requiring former employees to pay all or a greater portion of the cost of coverage, subject to applicable collective bargaining agreements.

Continued Coverage Under COBRA

Once the former employee's right to extended coverage ends, the former employee or his/her covered dependents may be eligible to elect to continue coverage under COBRA for up to an additional six months by

paying 102% of the group rate (see Section 16). At the appropriate time, the Company will provide you with information on how to elect continued coverage under COBRA.

CONVERSION RIGHTS

If coverage terminates either for you or for one of your dependents, and COBRA coverage is not elected, you currently may be able to convert coverage to a non-group policy issued by Blue Cross and Blue Shield of Alabama (see Section 16).

This non-group coverage currently provides hospital, limited surgical, and medical benefits different from those

SECTION 16. YOUR COBRA RIGHTS

In 1986, the Consolidated Omnibus Budget Reconciliation Act (COBRA), was enacted. COBRA is a federal law that requires that most employers sponsoring group health plans offer employees and their dependents the opportunity for a temporary extension of health coverage ("COBRA coverage") at 102% of group rates in certain instances where coverage would otherwise end or change. The information in this Section is intended to summarize your rights and obligations under COBRA. You, your spouse, and your other covered dependents should read this section carefully.

If you are an active regular employee or a regular employee on approved Leave of Absence, covered by the BellSouth Medical Assistance Plan or an alternative Health Maintenance Organization (referred to in this section as "the Plan"), you have a right to choose COBRA coverage for yourself and your covered dependents if you lose your coverage, or if your coverage changes because of the termination of your employment (for reasons other than gross misconduct on your part) or a reduction in hours.

If you are the spouse of an employee covered by the Plan, you have the right to choose COBRA coverage for yourself and your covered dependents if your coverage ends or changes due to any of the following events:

- The death of your active spouse,
- The death of your retired spouse, under certain circumstances, if within 18 months of your spouse's retirement,
- Termination of your spouse's employment (for reasons other than gross misconduct) or a reduction in your spouse's hours of employment,
- Divorce from your active spouse, **or**
- Divorce from your retired spouse, under certain circumstances, if within 18 months of your spouse's retirement.

In the case of a covered dependent, he/she has the right to elect COBRA coverage for himself/herself if coverage ends or changes for any of the following events:

- The death of a covered active employee,
- The death of a retired employee, under certain circumstances, if within 18 months of the employee's retirement,
- The termination of the covered employee's employment (for reasons other than gross misconduct) or a reduction in the covered employee's hours,
- Divorce of an active employee,
- Divorce of a retired employee, under certain circumstances, if within 18 months of the employee's retirement, **or**
- The dependent ceases to be a dependent under the provisions of the Plan.

Under the law, the employee or a family member has the responsibility to inform the Benefit Office

When the Benefit Office is notified that one of these events has happened, you will be notified regarding COBRA coverage. Under the law, you have 60 days from the later of the following two dates to elect COBRA coverage:

- The date you would lose coverage, or coverage would change because of one of the events described above, **or**
- The date the COBRA Election Form is sent to you from the Benefit Office.

If you do not choose COBRA coverage, your coverage will end or change in accordance with MAP's provisions.

If you choose COBRA coverage, the Company is required to give you coverage identical to the coverage provided under the Plan to active employees in similar situations, as of the time coverage is being provided. The law requires that you be allowed the opportunity to maintain COBRA coverage for 36 months unless you lost coverage, or coverage changed because of a termination of employment or reduction in hours. In those cases, the required COBRA coverage period is 18 months; however, the 18-month period may be extended to a 29-month period if you were classified as disabled by the Social Security Administration as of the last day of active employment.

The law also provides that your COBRA coverage may be cut short for any of the following reasons:

- The Company no longer provides any group health coverage to any of its employees
- The charge for your COBRA coverage is not paid on a timely basis
- You become covered under another group medical plan, unless the new coverage contains an exclusion or limitation which affects the COBRA-covered individual due to a pre-existing condition
- You become entitled to Medicare

You do not have to show that you are insurable to elect COBRA coverage. However, under the law, you will have to pay up to 102% of the group rate for your COBRA coverage during your 18 or 36-month period. In addition, if you are receiving Social Security disability benefits, the cost of your COBRA coverage during your 19-29 months of extended coverage will be 150% of the group rate.

The law also states that at the end of the maximum available continuation coverage period (18, 29, or 36 months), you must be allowed to convert your coverage to the individual health plan then provided under MAP to the extent, and under the same terms and conditions, that an individual conversion right otherwise is generally available to active employees in similar situations when your COBRA coverage terminates.

SECTION 17. OTHER IMPORTANT INFORMATION

INTRODUCTION

In 1974, Congress enacted the Employee Retirement Income Security Act (ERISA) to safeguard your interests and those of your beneficiaries under your employee benefit plans. As ERISA requires, this Section provides additional information about your benefits as well as a statement of your rights and protection under this law.

FUNDING

BellSouth currently provides for the payment of MAP benefits through one of two established Trusts: one for management employees and a negotiated Trust that covers non-management employees. These Trusts fund post-retirement and active health benefits for employees and their covered dependents. The Trusts also accept participant contributions for medical coverage. In addition, to meet MAP's obligations, the Participating Companies make periodic contributions. The Trustee is:

NationsBank
Master Trust–Southeast
600 Peachtree St., N.E.–7th Floor
Atlanta, Georgia 30308

Benefit payment checks that are not cashed within 180 days after the date of the check will be considered null and void, and the benefit so paid will be forfeited. All forfeited amounts will be re-deposited into the Trust from which paid. Any benefit so forfeited may be reinstated by filing a claim for the forfeited amount and satisfactorily

PLAN ADMINISTRATOR

The Plan Administrator is BellSouth Corporation, Room 7B09, 1155 Peachtree Street, N.E., Atlanta, Georgia 30367-6000.

BellSouth has delegated responsibility for handling Plan administrative services for each Participating Company as follows:

- BellSouth Business Systems
- BellSouth Communications, Inc.
- BellSouth Communications Systems
- BellSouth Corporation
- BellSouth D.C., Inc.
- BellSouth Telecommunications, Inc.

ACTIVES:
Secretary
Employees' Benefit Committee
Suite 1400
3000 Riverchase Galleria
Birmingham, Alabama 35244

- BellSouth Enterprises, Inc.
- BellSouth Financial Services Corporation
- BellSouth Information Systems, Inc.
- BellSouth International, Inc.
- BellSouth Resources, Inc.
- Intelligent Media Services, Inc.
- Intelligent Messaging Services, Inc.
- Sunlink Corporation

Secretary
BellSouth Enterprises Employees' Benefit Committee
Suite 5C, 1100 Peachtree Street
Atlanta, Georgia 30309
404-249-4175

- BellSouth Advertising & Publishing Corporation

Assistant Secretary
BellSouth Enterprises Employees' Benefit Committee
59 Executive Park South, N.E.
Atlanta, Georgia 30329
404-982-7027

- BellSouth Cellular Corporation

Assistant Secretary
BellSouth Enterprises Employees' Benefit Committee
Suite 600
5600 Glenridge Drive
Atlanta, Georgia 30342
404-847-3650

PLAN ADMINISTRATION

BellSouth has delegated to Blue Cross and Blue Shield of Alabama (and United HealthCare, Inc., with respect to QCP) the duty to administer all claims for Plan benefits for all Participating Companies. The Administrative Service Agreement between BellSouth Corporation and Blue Cross and Blue Shield of Alabama governs the operation of the Plan at all times. This agreement designates Blue Cross and Blue Shield of Alabama as the Claims Administrator. Blue Cross and Blue Shield of Alabama and with respect to QCP, United HealthCare, Inc., have complete discretionary authority to determine benefits under the Plan and to interpret the terms and provisions of the Plan. Their determinations and interpretations are final and conclusive.

As a contract holder receiving plan benefits, authorization is given to all payees (hospital, physicians, labs, etc.) receiving money in connection with this plan to release medical information to the Plan Administrator or a designated Auditor on behalf of you and your dependents.

SUBROGATION

Subrogation is the right of an individual/entity that has paid another individual/entity's legal obligation to recover

You are required to provide the Company with any information it may need to pursue its subrogation rights, and your receipt of any benefits under this Plan is subject to the Company's subrogation rights. Failure to cooperate in supplying the Claims Administrator with necessary information could result in the suspension of Plan benefits.

NOTIFICATION OF DENIAL OF BENEFITS

If a request for Plan benefits is denied, either in whole or in part, you or your dependents will receive written notification from Blue Cross and Blue Shield of Alabama. Notification will include:

- The specific reason(s) for the denial
- Specific reference to pertinent Plan provisions on which the denial is based
- A description of any additional material or information necessary for the individual to perfect the benefit request and an explanation of why such material or information is necessary
- Appropriate information as to the steps to be taken if you, your dependent, or a duly authorized person representing you or your dependent, wish to submit the benefit request for review

If you do not hear from Blue Cross and Blue Shield of Alabama within 90 days after your benefit request has been submitted according to the procedures in Section 14 of this booklet, your request is deemed to have been denied.

REVIEW PROCEDURES

If a request for benefits is denied, or you or your dependents feel you have been treated unfairly with respect to the Plan, you, your dependent, or a duly authorized person may request a review of the denied claim or other action within 180 days after you receive notification of the decision. You may call Blue Cross and Blue Shield of Alabama or submit a written request for review of any denied benefit payment or other disputed matter, accompanied by any additional documents or records to support the review.

Review requests should be mailed to:

BellSouth Review Facilitator
Blue Cross and Blue Shield of Alabama
P.O. Box 13126
Birmingham, Alabama 35202-3126

ERISA APPEAL PROCEDURES

If your request for review results in the denial being upheld, you, your dependent, or a duly authorized person may request an ERISA appeal. You must submit a written request for appeal within 100 days after your receipt of notification of the Review decision. Written request for an appeal of any denied benefit payment or other disputed matter should be sent directly to Blue Cross and Blue Shield of Alabama and should be accompanied by any additional documents or records to support the appeal. The person sending the request has the right to:

- Review pertinent Plan documents which may be obtained by following the procedures described in this Section.
- Send Blue Cross and Blue Shield of Alabama a written statement of the issues and any other documents in support of the request for benefits or other matter regarding the Appeal.

Appeal requests should be mailed to:

BellSouth ERISA Appeals Coordinator
Blue Cross and Blue Shield of Alabama
P.O. Box 13126
Birmingham, Alabama 35202-3126

Blue Cross and Blue Shield of Alabama is responsible for coordinating the appeals process under ERISA for all denials reported on the "Claims Report" except those involving enrollment status. The "Claims Report" will

direct the claimant to the appropriate Benefit Committee Secretary, Assistant Secretary, or Operations Manager (as shown on pages 92-93) in any case involving a denial based on ineligibility of the claimant.

If any part of a denial is based on a decision by United HealthCare, they will re-evaluate their decision and provide a final determination to Blue Cross and Blue Shield of Alabama for use in notification to the claimant.

Likewise, Blue Cross and Blue Shield of Alabama will re-evaluate any part of the denial that is based solely on its decision and make a final determination. Because this determination is final, it is important that you forward all information to Blue Cross and Blue Shield of Alabama for consideration in its review of your appeal.

In all appeal cases, a response will be provided to the claimant within 60 days after the appeal is received. As a participant in the Plan, you may have further rights under ERISA (see page 98). In this respect, BellSouth, the Plan Administrator, retains the right to interpret the Plan's provisions and to make final decisions regarding covered expenses and eligibility.

LEGAL SERVICE

Service of legal process in a cause of action with respect to any and all provisions of the Administrative Service Agreement should be directed to the BellSouth ERISA Appeals Coordinator.

Service of legal process concerning the Plan may also be directed to the appropriate Benefit Committee Secretary, Assistant Secretary, or Operations Manager or the Trustee (see pages 92-93.)

PLAN RECORDS

The Medical Assistance Plan and all its records are kept on a calendar-year basis.

PLAN IDENTIFICATION NUMBERS

The Plan is identified by the following numbers under Internal Revenue Service rules:

Employer Identification Number assigned to BellSouth Corporation by the IRS: 58-1533433

Plan Number assigned by the Company: 540

PLAN CONTINUANCE

The Company currently intends to continue the Medical Assistance Plan for active and former employees and retirees under the terms of the Plan, but reserves the right to amend or terminate it at any time, subject to any applicable collective bargaining agreements.

The benefits described in this booklet reflect the provisions of the Medical Assistance Plan as outlined in the current collective bargaining agreements, if any, between the Participating Companies and the various unions representing employees of those Companies in collective bargaining units. Copies of these collective bargaining agreements are distributed or made available to employees covered by them upon request.

PLAN DOCUMENTS

This booklet is a summary of the Medical Assistance Plan and does not attempt to cover all details. Specific details are contained in the Administrative Service Agreement between Blue Cross and Blue Shield of Alabama and BellSouth Corporation which legally governs the operation of the Plan. Plan participants are entitled to examine, free of charge, Plan contracts and documents, in accordance with, and as defined by ERISA, including the Administrative Service Agreement, the annual report of Plan operations, and other such documents and reports maintained by the Plan or filed with a federal government agency.

These contracts and documents are available for review during normal working hours at your Plan Administrator's Office. If you are unable to examine these contracts and documents there, you should write to the appropriate Benefit Committee Secretary, Assistant Secretary, or Operations Manager (see pages 92-93) specifying the contracts and documents to be examined and at which Company work location you wish to examine them. Copies of such contracts and documents will be made available for examination at that work location within 10 days of the date the request was received.

At any time, you may request copies of any Plan contracts and documents by writing to the appropriate Benefit Committee Secretary, Assistant Secretary, or Operations Manager (see pages 92-93). You will be charged a reasonable fee for copies.

YOUR RIGHTS AS A PLAN PARTICIPANT

MAP benefits are covered by the Employee Retirement Income Security Act of 1974 (ERISA). ERISA was signed into law for the purpose of protecting your rights under employee benefits plans. The law does not require a company to provide benefits, but it sets standards for benefits a company wishes to offer, and it requires that you be given an opportunity to learn about your rights under the law.

It is your right to know as much as possible about your benefits. This booklet is one way to keep you informed. As a participant in MAP, you are entitled to certain rights and protection under ERISA. ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents, as defined by ERISA, including contracts, collective bargaining agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. A reasonable charge may be made for such copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants according to the Plan's provisions. No one, including your employer and your union may fire or otherwise discriminate against you to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your request for a benefit under this Plan is denied, in whole or in part, you must receive a written explanation of the reasons for the denial. You have the right to formally appeal a denial for review and reconsideration (see page 95).

Under ERISA, there are steps you can take to enforce the rights outlined in this section. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a request for benefits which is denied or ignored, in whole or in part, you may file a legal action to recover these benefits. If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who will pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your request is frivolous.

If you have any questions about this statement of your rights, or your rights under ERISA, you should contact the nearest Area Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor.

EXHIBIT 2 OF APPENDIX A

Dental Assistance Plan

Table of Contents

Dental Assistance Plan

Introduction

A good smile and strong teeth are more than cosmetic assets—they're an important part of good health. The BellSouth Dental Assistance Plan (DAP) encourages employees to have regular preventive dental care and helps pay for dental care for you and each of your eligible dependents.

If you are a regular full-time employee with six months of service, your company will pay the entire cost for the Dental Assistance Plan for you and your eligible dependents. If you are a regular part-time employee with six months of net credited service, you may choose to participate in the plan, and your company will contribute at least part of your premium amount based on your date of hire.

The plan pays 100 percent of reasonable and customary charges for some covered preventive and diagnostic services. For other covered dental services, the plan pays according to a schedule. You pay a $25 deductible per covered person once each calendar year, unless one preventive treatment has been obtained within 12 months prior to the date of the treatment. You have a choice of dentists, and a predetermination of benefits option lets you and the dentist know in advance how much the plan will pay.

The plan covers only certain dental services and procedures. The most common exclusions are listed in this summary plan description.

Your Dental Assistance Plan coverage stops at the end of the month you leave your company, although you may have options for continuing coverage. If you retire on a service or disability pension, you and your eligible dependents will continue to be eligible for coverage. However, if you retired on or after Jan. 1, 1988, you will have to pay for any dependent (other than your spouse) added to your contract after retirement.

Effective Jan. 1, 1993, if you retired on or after Jan. 1, 1992, the cost of coverage for you, your spouse and other dependents will be paid by the company only up to the 1990 actual cost level. The schedules included in this summary plan description were effective on Jan. 1, 1993.

DAP is classified under the definitions of the Employee Retirement Income Security Act of 1974 (ERISA) as a welfare plan, and its original effective date was Jan. 1, 1983. Key features of the plan are explained on the following pages.

This summary plan description provides only a summary of the Dental Assistance Plan to answer some of the questions you may have about the plan. The summary plan description will be updated periodically to describe changes in the plan. There could be a delay between the time a change becomes effective and the date you receive a description of the change. Contact the plan administrator if you have questions about the plan's current provisions and benefits.

Please read this summary plan description carefully and keep it handy for ready reference.

Eligibility

For Employee or Retiree

If you are a regular full-time or part-time employee of a participating company, you are eligible for coverage under this plan on the day you attain six months of net credited service.

If you are a retired employee on a service or disability pension, you are eligible for coverage under this plan.

Regular full-time employees are covered automatically by the plan on the date they reach six months of net credited service. When regular part-time employees earn six months of net credited service, they must enroll for coverage under the plan.

For Spouse and Children

Your dependents will be covered by the plan on the same day your coverage becomes effective, provided you have enrolled them and provided the company pays the full cost of your coverage. If you enroll them later, their coverage will be effective on the date they meet eligibility requirements. If you enroll dependents after you retire, your dependents' coverage will be effective on the first day of the month after you enroll them.

Dependents include:

- your spouse;
- your unmarried children living with you, who may be covered until the end of the year in which they reach age 19 or, if they are full-time students, until the end of the year in which they reach age 23; and
- your unmarried child who is physically or mentally handicapped and is fully dependent on you for support.

Children include your natural children, legally adopted children, stepchildren or children for whom your spouse or you have been granted by a court a permanent legal guardianship and who live with you.

In cases where a legal relationship other than a permanent legal guardianship has been granted, in order for a child to be eligible for DAP coverage, all of the following criteria must be satisfied:

- The adult granted the relationship is a DAP participant.
- A court has ordered or approved the relationship, which:
  - is intended to remain in effect until such time that the child reaches majority.
  - imposes all of the legal obligations and rights on the adult that would exist in a normal parent/child relationship, including, but not limited to, full-time responsibility for housing, feeding, educating, clothing and disciplining the child.
- The relationship described above must have existed for a period of at least 12 months prior to a request for DAP coverage and must be verified through the presentation of the legal documents and court order that established the relationship.

If Both Parents Work for BellSouth

If you and your spouse both work for the same BellSouth company, one of you may waive coverage as an employee and be covered as a dependent under the other's coverage. If you and your spouse are employees of different BellSouth companies, each of you is covered

only as an employee. You should enroll eligible children for coverage by the parent whose birthday comes first in a calendar year.

No person can be covered as both an employee and a dependent under this plan, or as a dependent of more than one employee.

Eligibility for or participation in the plan does not constitute a guarantee of employment, nor does it interfere with the company's right to terminate employment.

Benefits

Coverage

The Dental Assistance Plan pays a maximum of $1,210 in benefits in a calendar year for you and $1,210 in a calendar year for each eligible dependent. There are also lifetime maximums for orthodontics and temporomandibular joint (TMJ) dysfunction.

The plan pays 100 percent of reasonable and customary charges for certain preventive and diagnostic care, called "Type A" services. Reasonable and customary charges are the actual fees charged by a dentist for a service rendered or a supply furnished. Provident Life and Accident Insurance Company, the claims administrator, determines what amount of a fee is reasonable. In making that judgment, Provident considers the following:

- The usual fee which the individual dentist most frequently charges the majority of patients for a service rendered or supply furnished;
- The prevailing range of fees charged in the same area by dentists of similar training and experience for the service rendered or supply furnished; and
- Unusual circumstances or complications requiring additional time, skill and experience in connection with particular dental services or procedures.

For other kinds of care, called "Type B" services, the plan pays according to a schedule (see Appendix II). Dollar amounts in the schedule are the maximum amount the plan will pay for a particular procedure. Before Type B benefits can be paid, you pay the first $25 of the scheduled allowances for you and each eligible dependent. A family limit applies after the deductible has been paid by three covered family members during a 12-month period. When this happens, the deductible for your entire family has been satisfied for that year.

The $25 deductible is waived when one preventive treatment is done within 12 months prior to the date you incur Type B services. This waiver applies separately to each covered person once each calendar year. Preventive treatment means routine cleaning and scaling of teeth, application of sealants for children under age 13 and fluoride treatments that qualify as Type A services.

In addition, the $25 deductible will be waived for participants who have complete (upper and lower) dentures.

Type A Services

Type A services, for which the plan pays 100 percent of the reasonable and customary charges, are:

- Routine oral examinations, but not more than two examinations in a calendar year. These exams are for diagnosing your oral health and determining what dental care you need.
- Prophylaxis (cleaning and scaling your teeth), but not more than twice in a calendar year,

when performed by a dentist or a dental hygienist.

• Fluoride treatments, excluding prophylaxis, when performed by a dentist or dental hygienist, including:

- Topical (local) application of sodium fluoride, but not more than four treatments in a calendar year, or
- Topical application of stannous fluoride, but not more than one treatment in a calendar year, or
- Topical application of acid fluoride phosphate, but not more than one treatment in a calendar year.

• Space maintainers (for dependent children under age 19 only), including installation of fixed or removable appliances designed only to maintain existing space created by the premature loss of teeth.

• Dental X-rays or radiographs, including:

- Full-mouth panorex X-rays, but not more than once in five consecutive calendar years;
- Supplementary bitewing X-rays, but not more than twice in a calendar year; and
- Any dental X-ray required to diagnose a specific condition that needs treatment, except X-rays in conjunction with orthodontia and TMJ.

NOTE: X-rays must be furnished to Provident

• Restorations, including fillings, inlays, onlays and crowns: treatment necessary to restore the structure of a tooth or teeth which have major decay or fracture. Inlays, onlays and crowns are covered only when a less costly restoration would not restore the teeth. (See the section, "Alternate Procedures.")

• Oral surgery: surgical procedures in and about the mouth.

• Endodontics, such as root canal work: procedures used for the prevention and treatment of diseases of the dental pulp (or root), excluding sedative bases or liners and implants.

• Periodontics: non-surgical and surgical procedures for treatment of the supporting area around the teeth.

• Prosthodontics: services to replace one or more teeth except third molars (wisdom teeth), extracted while the patient is covered under the plan. This includes:

- Initial installation of fixed bridge work, including inlays and crowns to form supports (abutments).
- Initial installation of removable partial or full dentures, including adjustments during the six-month period after they are installed.
- Adding teeth to an existing removable partial denture or to bridge work because of additional extractions.
- Installing a permanent full denture that replaces the teeth and is installed